Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Northwest Texas Healthcare

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-15-1339-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
January 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As these services were not subjected to a prior medical necessity review, we ask that you evaluate the treatment in question pursuant to 28 Tex. Admin. Code 19.2015 (Regarding "Utilization Review for Healthcare Provided under Worker's Compensation Insurance Coverage") This section specifically allows for "Retrospective Review of Medical Necessity," and requires carriers to perform "such retrospective… under the direction of a physician."

Amount in Dispute: $343.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The surgical procedure, code 11042, performed on the date above was not a medical emergency by the submitted documentation and definition of such at Rule 133.2. Thus, the procedure required preauthorization. No payment is due."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17 – 20, 2014	G0463, 11042	$343.22	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of healthcare.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 930 – Preauthorization required. Reimbursement denied

Issues

1. Did the requestor support request for retrospective review?

2. Is the requestor entitled to reimbursement?

Findings

1. The requestor in their position statement state, "pursuant to 28 Tex. Admin. Code 19.2015 (Regarding "Utilization Review for Healthcare Provided under Worker's Compensation Insurance Coverage") This section specifically allows for "Retrospective Review of Medical Necessity," and requires carriers to perform "such retrospective… under the direction of a physician." The Texas Register, Title 28, Rule §19.2015 (2), in pertinent part states, " such retrospective review shall be under the direction of a physician and performed in accordance with Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers). These services were not denied for medical necessity. The disputed services were denied for lack of pre-authorization as required by rule 134.600 (p) "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section;".
2. Review of the submitted medical claim finds;
    a. Type of bill in box 4 of UB-04 CMS-1500 "131" Outpatient Hospital
3. 28 Texas Administrative Code §134.600 (7) states, "Outpatient surgical services: surgical services provided in a freestanding surgical center or a hospital outpatient department to patients who do not require overnight hospital care." Documentation submitted supports disputed services were performed in an outpatient hospital setting and therefore required prior authorization. The carrier's denial is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		April , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.